DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106027	A. BUILDING _____ B. WING _____	R-C 01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT ORLANDO INC	2000 NORTH SEMORAN BOULEVARD ORLANDO, FL 32807

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{F 000}	INITIAL COMMENTS	{F 000}		

Complaint Investigations #2016012160 and #2016013398 were conducted from to . Avante at Orlando was not in compliance with 42 CFR 483 and 488, requirements for long-term care facilities.

Immediate Jeopardy was identified starting on and on is ongoing.
The Administrator was notified of Immediate Jeopardy at 1:45 PM on .
A Partial Extended survey was conducted on . Immediate Jeopardy remains ongoing at that time.

Non-compliance was identified at the Immediate Jeopardy level for F271, F281, F309, F386, and F388, with Substandard Quality of Care for F309 starting on at a severity and scope of J.

An onsite visit to verify removal of Immediate Jeopardy was conducted on . The Immediate Jeopardy was removed as of the date on the allegation of removal of immediacy, / .

The severity and scope of the following deficiencies was lowered to D- , no actual harm with potential for no more than minimal physical, mental, and/or psychosocial harm to residents due to the need to develop and submit a plan of correction to include what measures will be put into place to ensure that the deficient practice will not recur and how the facility plans to monitor its performance to make sure that solutions are sustained:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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{F 000}	Continued From page 1 F271 §483.20(a) Admission Orders for Immediate Care F281 §483.21(b)(3) Services Provided Meet Professional Standards F309 §483.24, 483.24(k)(l) Provide Care/Services for Highest Well Being F386 §483.30(b)(1)-(3) Physician Visits-Review care/notes/orders F388 §483.30(c)(3)(4) Personal Visits by Physician	{F 000}		
{F 157} SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ . . . . I, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	{F 157}		

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(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

( ) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on interview, record review and policy review, the facility failed to notify an interested family member regarding holding services for 1 of 4 residents reviewed for (#4).

Findings:

Resident #4 was discharged from the Long Term Care hospital (LTCH) and admitted to the facility on with diagnoses including Chronic Kidney , Dependence on (kidney), Anoxic Damage, of Sacral Region, and " " is the clinical purification of to substitute for the absence of normal kidney function and anoxic

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This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F 157. Notify of changes/Injury/Decline/
1. Immediate actions taken:
Resident # 4 was a closed chart and no longer resides in the facility.
During survey conducted

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damage is the lack of for several minutes or longer. cells begin to die after approximately 4 minutes without ." (Oxford dictionary).

Documentation from the LTCH's Nephrologist's (kidney doctor) orders, dated / through , revealed that resident #4's laboratory work (labs) were being closely monitored to determine the duration and frequency of the resident's treatments. The LTCH Discharge Summary, dated , indicated resident #4's kidney function was being closely monitored and she would be discharged from the hospital. "Kidney function tests are common lab tests used to evaluate how well the kidneys are working." (medlineplus.gov). The physician addressed with resident #4's family the diagnosis of due to Chronic Kidney , the need for , and the need to be followed by a nephrologist. The family voiced understanding and wished the resident be placed in a skilled nursing facility for further care. Review of the resident's medical records from the LTCH did not reveal any discussion with the family regarding discontinuation of .

On at 2:57 PM, the North Wing unit manager (UM) Licensed Practical Nurse (LPN) A confirmed that she was the nurse who took the order from Nurse Practitioner (NP) C for resident #4 on for in-house on Tuesday, Thursday and Saturday to start on / . LPN A also confirmed that she took another order from NP C to hold on / . LPN A said that typically when there is a change in plan of care, the resident's representative is notified. However she could not recall if the family or resident representative was

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2016 through , 2016 and on , 2017, the medical record for all residents on were reviewed by the DON and RN corporate nurse to determine if any changes in condition occurred that were not communicated to the resident representative and Physician/Nurse Practitioner. Review confirmed that all changes in condition had been appropriately communicated to the resident representative and Physician/Nurse Practitioner, as appropriate, for all residents on .

2. Identification of other residents having the potential to be affected: Director of Nursing (DON) or designee continued from , 2017 and onward, reviewing new orders of current residents and residents on at risk for change in condition to determine if there were any changes in condition that occurred that were not communicated to resident s responsible party and Physician/Nurse Practitioner. Review confirmed that all changes in condition had been appropriately communicated to the resident representative and Physician/Nurse Practitioner, as appropriate, for all residents on .

3. Actions taken/systems put into place to reduce the risk of future occurrence: Director of Nursing (DON) or designee finalized reeducation on , 2017 to all licensed nurses, social services, dietary CDM and rehab staff on S 483.10(g) (14) notification of changes Director of Nursing (DON) or designee will continue to follow its current process, through white board process (clinical

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ever notified regarding the hold order.

The facility failed to follow the "Resident Rights" policy, dated 2016, which read, "Planning and implementing, the resident has the right to be informed of and participate in, his or her treatment, including: a. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. iii. The right to be informed, in advance of changes to the plan of care."

was placed on hold for seven (7) days from through , without any evidence that a discussion had taken place with an interested family member or resident representative regarding an alteration in the treatment, which is needed to sustain life.

On at 9:32 AM via telephone, the LTCH Nephrologist indicated he had written the order on to hold Resident #4's based on the laboratory value for , which was normal at that time. " has been found to be a fairly reliable indicator of kidney function." (medicinenet.com). The Nephrologist said, he had not had a conversation with the family regarding the discontinuation of , and she would have needed more labs ordered at a later date to make the decision if anymore was necessary.

{F 271} SS=D 483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE

(a) Admission orders

{F 157}

review for new admissions chart, physicians orders, consults, acute change in condition, labs, and risk management) and review orders daily, through existing TLC program, rounds conducted by nursing management team with focus on clinical needs and customer service, on current facility residents at least three times weekly, will continue to identify new changes in condition and ensure resident representative and physician/Nurse Practitioner is notified immediately in compliance with S 483.10(g) (14).

4. How corrective action will be monitored:

The Director of Nursing (DON) or designee will review orders at least three times weekly and participate in TLC rounds at least two times weekly to ensure all new changes in conditions are identified and communicate to resident representative and Physician/Nurse Practitioner in compliance with S 483.10(g) (14).

The Director of Nursing (DON) or designee will review results of review conducted as part of facility QAA/QAPI monthly for three months, quarterly for six months, then randomly thereafter.

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{F 271} Continued From page 5

At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to obtain admission physician orders for immediate and essential care regarding life sustaining care and services for 1 of 4 residents reviewed for (#4). This failure resulted in deterioration of the resident's condition to a level requiring re-hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired.

The facility's failure to obtain orders to monitor kidney status for the need for resulted in Immediate Jeopardy staring on . This deficiency resulted in Substandard Quality of Care. Immediate Jeopardy was determined to be ongoing as of .

Findings:

Cross Reference to F309, F281, and F386.
Resident #4 was discharged from the Long Term Care Hospital (LTCH) and admitted to the facility on , with diagnoses including Chronic Kidney , Dependence on Anoxic Damage, of Sacral Region and " is the clinical purification of to substitute for the absence of normal kidney function, and Anoxic damage is the lack of for several minutes or longer. cells begin to die after approximately 4 minutes without ."
(Oxford dictionaries).

{F 271}

F 271 Admission Physician order for immediate care.
1. Immediate actions taken:
Resident #4 had a closed chart and no longer resides at the facility.
During survey conducted on 27, 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse. Medical records review included but was not limited to all records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, /OT/ST evaluations/progress notes, active drug lists, medication orders, treatment orders, Physician progress notes, flow sheets, admission orders and interim care plans to determine if there were any residents that did not have orders for immediate care. Review confirmed that all residents on had orders to address immediate care.
On , 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new residents whether the resident would receive in-house or out-patient. This hold with remain in effect until the facility receives written clearance and confirmation of its substantial compliance.

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The resident's LTCH History and Physical, dated , indicated she was receiving treatments since her admission to the LTCH on . The most current documentation of the treatments was on the "Mobil Run Sheet", dated , and . The run sheets indicated that she required treatments up until the time she was admitted to the facility on , with the exception of a 1 time hold order on .

The resident's LTCH Discharge Summary, dated , indicated that she was followed by a Nephrologist (kidney doctor) while at the LTCH, was currently on , and discussion with the family indicated they wanted her to be transferred to a skilled nursing facility for further care.

Review of the facility's admission physician orders and nurses' notes for resident #4, dated , did not contain any documentation that the resident was to receive any or laboratory work (labs) to monitor kidney function.

On at 2:57 PM, Licensed Practical Nurse (LPN) A said that she called the physician on call on to obtain admission orders for . She said Nurse Practitioner (NP) C was taking calls for the primary care physician on . She obtained orders from NP C for in-house 3 times a week for resident #4. LPN A said she obtained additional admission orders from NP C on , the day the was to start, to hold treatments. LPN A was unable to verbalize why resident #4's was ordered and then placed on hold before it started.

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The Medical Director was notified of citations on , 2016 and again on , 2017.

2. Identification of other residents having the potential to be affected:
Director of Nursing (DON) or designee continues to review current residents records from , 2017 and onward, medical records reviewed included but was not limited to all records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, /OT/ST evaluations/progress notes, active drug lists, medication orders, treatment orders, Physician progress notes, flow sheets, admission orders and interim care plans to determine if there were any residents that did not have orders for immediate care. Review confirmed that all resident had orders to address immediate care.
3. Actions taken/systems put into place to reduce the risk of future occurrence:

On , 2016 the Director of Nursing (DON) or designee initiated re-education to all 26 licensed staff nurses and all scheduled contracted licensed nurses on the process of receipt and verification of orders including hold orders as well as completion and review of the interim care plans within 24hrs of admission. The education also included care of the resident on and the critical thinking skills needed to address hold orders including diagnostic

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Review of the physician orders, dated Wednesday , confirmed an order was taken by LPN A from NP C for in-house every Tuesday, Thursday and Saturday for resident#4's diagnosis of " is when the kidneys are no longer able to work at a level needed for day to day life." (medlineplus.gov).

Review of the physician orders, dated / , confirmed LPN A took another order from NP C, to hold for 7 days, starting 11/ through / . The orders did not include any labs to monitor the resident's kidney function while she was not receiving any .

On at 1:10 PM, the Director of Nursing (DON) confirmed that resident #4 was admitted to the facility on from the LTCH, and the facility had documentation that this resident was receiving services from a Mobil company prior to her admission to the facility. She said her last treatment for (HD) at the LTCH was on per the run sheets, and a physician progress note indicated that HD was on hold for .

Review of the LTCH orders and notes, dated / through , revealed resident #4's labs were being closely monitored to determine duration and frequency of the treatments. There was a one-time order to hold on , give , and obtain a BMP on . A Basic Panel (BMP) is a test that measures sugar (Glucose) level, electrolyte ( ) and fluid balance, and kidney function (WebMD.gov).

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tests and monitoring.
The Director of Nursing (DON) or designee completed re-education on , 2017 to all licensed nurses on S483.20 (a). Director of Nursing (DON) or designee will continue to follow its current process, through the white board process (clinical review for new admissions chart, physicians orders, consults, acute change in condition, labs, and risk management) reviewing orders daily in morning clinical meeting and reviewing orders for all new admissions to ensure residents have orders for immediate and essential care regarding life sustaining care and services.

4. How corrective action will be monitored:
The Director of Nursing (DON) or designee will audit the daily review of newly admitted residents at least three times weekly to ensure that newly admitted residents have orders for immediate care and essential care regarding life sustaining care and services.
The Director of Nursing (DON) or designee will review results of audits conducted as part of facility QAA/QAPI monthly for three months, quarterly for six months then randomly thereafter.

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A telephone interview was conducted on at 9:32 AM with the Nephrologist who treated resident #4 while at the LTCH regarding his order to hold on . The Nephrologist indicated he had written the order on to hold based on the most recent lab value for , which was normal on . The level shows how well your kidneys are working. A high level may mean kidneys are not working as they should (WebMD.gov). He said that no conversation had taken place with the family regarding the discontinuation of because there would have needed to be more labs at a later date to make the decision regarding the frequency of treatments. The Nephrologist also indicated he was not made aware of resident #4's discharge on , and would have continued close monitoring, additional labs, and sessions.

A review of the lab results from the LTCH, dated at 1:55 AM, indicated the resident's was no longer in the normal range, and was elevated.

On at 11:11 AM, NP C confirmed that he gave admission orders for 3 times per week on , and then changed it to hold on // . NP C said that he gave the orders based on the information provided to him via a telephone call from the facility staff on and // , but could not provide details of the information provided. After reviewing the resident #4's medical records on , NP C stated, "I cannot not find any evidence that the LTCH had any intention to stop

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(resident #4's) , and had I known that was only on hold for one day at the LTCH, I would have ordered a STAT (immediate) consult and Basic Panel. I can only base my decisions on the information provided to me by the facility since I did not see this resident until / ."

On at 3 PM, the DON confirmed that the facility received an initial referral via FAX on 11/01/16 from the LTCH regarding resident #4's admission to their facility and that they were aware that it was undecided as to whether or not the resident would be getting at their facility. The DON said that the resident did not have a nephrologist when she entered their facility on because she was not getting anymore. The DON stated, "the Nurse Practitioner should have ordered the consult and I should have probed the primary care provider regarding, how do you want us to handle this since the resident's is on hold?"

Review of the acute care hospital "Physician Consultation", dated /, the day resident #4 was sent to the hospital from the Skilled Nursing Facility, revealed the resident was assessed to have Severe Azotemia and Uremia causing the resident to have a change in mental status, Acidosis from possible and missing , along with hyperkalemia (high) from Failure and Acidosis. The physician placed an order for resident #4 to begin STAT (immediately) with prognosis listed as poor.

Resident #4's "Physician Consultation", dated , the day the resident was sent to the

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hospital from the SNF, reflected the resident had "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and Missing along with Hyperkalemia from Failure and Acidosis. The physician ordered Resident #4 to begin immediately with the prognosis of "POOR". Azotemia means "insufficient kidney filtering." (Azotemia.net). Uremia is a "serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them." (WebMD.com). Acidosis "is a condition in which there is too much in the body fluids." (Medlineplus.gov). The resident received hospice care within 5 days of transfer to the acute care hospital on /, and expired on .

Review of the facility policy "Admission Orders", dated 2014, read, "The facility will obtain physician orders for the immediate care of the resident upon each admission to ensure the resident receives necessary care and services."

Resident #4 did not receive the necessary care and services regarding which is needed to sustain life. Review of the facility records from to / revealed that at no time during her stay at the facility were any orders for essential care obtained for consult or labs to monitor her kidney function after the was placed on hold.

The facility implemented sufficient measures to remove the immediacy and decrease the severity/scope as of /, but the facility remains out of compliance with F271. The severity and scope of the deficiency was lowered

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{F 271}	Continued From page 11 to D- , no actual harm with potential for no more than minimal harm to residents. As of , the plan of correction was not submitted to include the facility's plans to fully implement, monitor performance, and evaluate the effectiveness of their action plans to ensure sustained compliance.	{F 271}		
{F 278} SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	{F 278}		

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subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to accurately assess the status for 1 of 4 sampled residents reviewed for (#4).

Findings:

Resident #4 was admitted to the facility on . Review of the Minimum Data Set (MDS) 5 Day assessment dated / indicated that during the 14-day lookback period while not a resident and while a resident; she had the following special treatments, procedures, and programs: , suction and care. The MDS nurse did not assess the resident as receiving any in the 14-day lookback period while not a resident, to .

Review of the resident #4's medical record revealed the presence of run sheets dated , , and from the Long Term Care Hospital which would indicate that the resident received on those days.

On at 2:25 PM, MDS Coordinator H confirmed that she did the assessment for resident #4 dated /. She said she saw the resident on / and noted that she had a right chest . Dependence on kidney was included in the diagnosis

F 278 Assessment Accuracy/Coordination/Certified
1. Immediate actions taken:
Resident #4 had a closed chart and no longer resides at this facility.
An audit was conducted on , 2017 of the Special services section of the MDS for all residents on were reviewed by MDS Co-coordinator to ensure that all services listed under the Special Services section of the MDS were accurately coded. The audit and review confirmed that Special Services sections for all reviewed residents were accurately coded.
2. Identification of other residents having the potential to be affected:
The facility MDS Coordinator reviewed current residents that receive special services on , 2017 to ensure accurate coding on the MDS. This review confirmed that all residents MDS reviewed had accurate MDS coding.
3. Actions taken/systems put into place to reduce the risk of future occurrence:
The MDS coordinator will conduct audits of all new residents MDS for Special services weekly for eight weeks and randomly thereafter.
4. How corrective action will be monitored:
The Director of Nursing (DON) or

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{F 278}	Continued From page 13 section of the assessment. MDS Coordinator H said she did not know that the resident had her last treatment on , and since she did not see any flow sheets in the medical record, she then assessed the resident as no in the 14-day look back period for special treatments, procedures and programs.	{F 278}	designee will review the MDS audits weekly for eight weeks to ensure MDS special services section is coded accurately. The Director of Nursing (DON) or designee will review results of audits as part of the facility QAA/QAPI monthly for three months and then randomly thereafter.	
{F 281} SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, the facility failed to provide services to meet professional standards of quality for 1 of 4 sampled residents reviewed for treatments (#4). The resident's condition deteriorated to a level requiring hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired. The facility's failure to monitor kidney status to identify the need for resulted in Immediate Jeopardy, staring on . This deficiency resulted in Substandard Quality of Care. Immediate Jeopardy was determined to be	{F 281}	F 281 Services provided meet professional standards. 1. Immediate actions taken: Resident #4 had a closed chart and no longer resides at this facility. During survey conducted , 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse, records reviewed included but was not limited to, records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, /OT/ST evaluations/progress notes, active drug lists, medication orders, treatment orders,	

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ongoing as of .

Findings:

Florida Board of Nursing, Nurse Practice Act, 464.003 (3)(a)(1)(2), states that "The practice of professional nursing means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of , biological, physical, and social sciences which shall include, but not be limited to: (1) the observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or informed; and the promotion of wellness, maintenance of health, and prevention of illness of others, (2) the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to subscribe such medications and treatments, (3) the supervision and teaching of other personnel in the theory and performance of any of the above acts."

Review of documentation from a long-term care hospital (LTCH), dated , indicated Resident #4 was hospitalized after a motor vehicle accident and apparent . The resident was intubated and suffered an Anoxic . Anoxic is "the lack of inadequate for several minutes or longer. cells begin to die after approximately four minutes without ." (Oxford dictionary). Resident #4 was also assessed to be in Acute (kidney) Failure, and in need of . Acute Failure means "the kidneys are unable to excrete the daily load of toxins in the ." (Oxford

{F 281}

Physician progress notes, flow sheets, admission orders and interim care plans to ensure that immediate care needs were met and that facility monitored kidney status to identify the need for . All records reviewed confirmed there was evidence of appropriate monitoring of kidney status and all care needs were met.
On , 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new residents whether the resident would receive in-house or out-patient. This hold with remain in effect until the facility receives written clearance and confirmation of its substantial compliance.
The Medical Director was notified of citations on , 2016 and again on , 2017.

2. Identification of other residents having the potential to be affected:
On , 2016 the Director of Nursing (DON) or designee initiated re-education to all 26 licensed staff nurses and all scheduled contracted licensed nurses on the process of receipt and verification of orders including hold orders as well as the completion and review of interim care plans within 24hrs of admission. The education also included the care of the resident on and the critical thinking skills need to address hold orders specific to , including diagnostic tests and monitoring. All licensed facility staff

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dictionary). is "a process of purifying the of a person whose kidneys are not working normally." (Wikipedia). The LTCH history and physical dated indicated the plan was to continue and incorporate the services of , the branch of medicine that deals with the kidneys (thefreedictionary.com/) and , the medical specialty that is concerned with the diagnosis and treatment of (thefreedictionary.com/), and monitor the resident for kidney function.

The LTCH follow-up plan was to continue and incorporate the services of and and monitor the resident for kidney function. Review of the LTCH orders dated / through revealed Resident #4's labs were being closely monitored to determine duration and frequency of the treatments.

Review of the LTCH "Discharge Summary", dated , indicated Resident #4 had been closely monitored and would be discharged from the LTCH to a Skilled Nursing Facility (SNF). A discussion was conducted with the family addressing diagnosis of in Chronic Kidney along with the need for and to be followed by the kidney doctors. The family voiced understanding and wished to get the resident to a SNF for further care.

Resident #4 was discharged from the LTCH and admitted to the SNF on with diagnoses including in Chronic Kidney , Dependence on , Failure, Anoxic , a of

nurses were re-educated as of 10, 2017 and all contracted nurses are re-educated prior to being placed on an assignment.
The Director of Nursing (DON) or designee continues to review orders for current residents on , 2017 and onward to ensure that the facility is monitoring residents process with standards that meet professional standards as stated in the Nurse Practice Act S464.003 (3) (a) (1) (2). All records reviewed confirmed there was evidence of the appropriate monitoring and management of residents processes.

3. Actions taken/systems put into place to reduce the risk of future occurrence:
The Director of Nursing (DON) or designee initiated re-education on , 2017 to all licensed nurses on standards that meet professional standards as reflected in the Nurse Practice Act S464.003 (3) (a) (1) (2). All nurses that have not received re-education on , 2017 will be re-educated prior to being placed on an assignment. The Director of Nursing (DON) or designee will continue, through the white board process (clinical review for new admissions chart, physicians orders, consults, acute change in condition, labs, and risk management) and review orders, interim care plans for all new admissions daily to ensure orders and interventions are present that reflect the management and monitoring of residents processes.

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the Sacral Region, and .

Review of the facility's admitting physician orders for Resident #4 dated , did not contain any documentation that the resident was to receive . Admitting nurses' notes for Resident #4, dated , contained no documentation that the resident was to receive . Resident #4's admitting care plan, dated , did not contain documentation that the resident was to receive and did not contain interventions to guide care.

On at 1:10 PM, the Director of Nursing (DON) confirmed the resident was admitted to the facility from a LTCH on along with documentation the resident was receiving at the LTCH. The DON indicated the resident's last treatment in the LTCH for was dated . In the discharge orders from the LTCH there was an order to "hold the on ". The DON was unable to explain the lack of monitoring and follow-up treatment for Resident #4.

Resident #4's record revealed a physician order had been written by a Nurse Practitioner (NP C) on , to begin in-house on Tuesday, Thursday and Saturday starting on / . The order was later discontinued by an order placed to hold for Resident #4 for seven days, from / through / .

On at 2:57 PM, an interview was conducted with the Unit Manager on the North Wing, Licensed Practical Nurse (LPN) A, who had received the new physician orders regarding for Resident 4. LPN A indicated she

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4. How corrective action will be monitored:
The Director of Nursing (DON) or designee will audit the daily review of newly admitted resident orders and interim care plans at least three times weekly to ensure orders and interventions are present that reflect the management and monitoring of residents processes.
The Director of Nursing (DON) or designee will review results of audits as part of the facility QAA/QAPI monthly for three months, quarterly for six months and then randomly thereafter.

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had called the facility ' s physician on call and had received the order to start and "hold" the [redacted] from the Nurse Practitioner (NP). LPN A also explained she had called the mobile [redacted] company who would be performing the "in-house" [redacted] treatments for Resident #4 and indicated the mobile [redacted] company had no record regarding [redacted] treatment for Resident #4. LPN A was unable verbalize why Resident #4's [redacted] was ordered then "held".

On [redacted] at 9:32 AM via telephone, nephrologist E who treated Resident #4 at the LTCH, indicated he had written the order on [redacted] to hold [redacted] based on a laboratory value for [redacted] which was normal at that time. He said no conversation had taken place with the family regarding the discontinuation of [redacted] as there would have needed to be more labs at a later date to make the decision if anymore [redacted] was necessary. Nephrologist E also indicated he was not made aware of the Resident #4's discharge and would have continued close monitoring and additional labs and [redacted] sessions.

On [redacted] at 10:40 AM, NP C, who had written the above orders concerning the plan of care for Resident #4, indicated any resident on [redacted] is closely monitored and if their [redacted] levels were becoming stable the resident would have repeat lab work to monitor the kidney function. He confirmed that no further labs were ordered by him to evaluate Resident #4's kidney function. NP C confirmed after reviewing records from the LTCH that the LTCH nephrologist had no intention of stopping Resident #4's [redacted]. NP C said that he

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gave an order for , on , and then to hold , on / based on the information provided by the facility. NP C also indicated he could not find any evidence that would indicate the was to be stopped and if he had known that the was only on "hold", he would have ordered a STAT (immediate) (kidney) consult. He said, "I can only base my decisions on the information provided by the facility. I did not see this resident until ."

Resident #4's Physician Consultation, dated 11/ , the day the resident was sent to the hospital from the SNF, reflected the resident had "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and Missing along with Hyperkalemia from Failure and Acidosis. The physician ordered Resident #4 to begin immediately with the prognosis of "POOR". Azotemia means "insufficient kidney filtering." (Azotemia.net). Uremia is a "serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them." (WebMD). Acidosis "is a condition in which there is too much in the body fluids." (Medlineplus.gov). The resident received hospice care within 5 days of transfer to the acute care hospital on 11/21/16, and expired on .

The facility policy "Physician Visits and Physician Delegation", no date, indicated the nurse is to clarify all orders as needed and to document any special discussion between the physician and the nurse.

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The professional nursing staff failed to clarify the need for treatment for Resident #4. The communication between LPN A and NP C did not explore past medical history and the need for follow-up kidney care. The professional nursing staff did not use nursing judgement to evaluate the need for monitoring kidney status, and the significance of orders to hold for an additional 7 days after admission from the LTCH to the facility.

The facility implemented sufficient measures to remove the immediacy and decrease the severity/scope as of , but the facility remains out of compliance with F281. The severity and scope of the deficiency was lowered to D- , no actual harm with potential for no more than minimal harm to residents. As of , the plan of correction was not submitted to include the facility's plans to fully implement, monitor performance, and evaluate the effectiveness of their action plans to ensure sustained compliance.

{F 309} SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING {F 309}

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25
(k) Pain Management.

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The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(I) . The facility must ensure that residents who require , receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review and policy review, the facility failed to provide (the clinical purification of to substitute for the absence of normal kidney function-oxford dictionaries) services along with monitoring kidney function for 1 of 4 sampled residents reviewed for , (#4). This life sustaining treatment (, .) was placed on "hold" without any monitoring to determine resident #4's level of kidney function during that time. The resident's condition deteriorated to a level requiring hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired.

The facility's failure to monitor kidney status to identify the need for resulted in Immediate Jeopardy, staring on . This deficiency resulted in Substandard Quality of Care. Immediate Jeopardy was determined to be ongoing as of .

Findings:

{F 309}

F 309 Provide Care/Services for the Highest Well Being
1. Immediate actions taken:
Resident #4 had a closed chart and no longer resides in the facility.
During survey conducted , 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse, records reviewed included but was not limited to, records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, /OT/ST evaluations/progress notes, active drug lists, medication orders, treatment orders, Physician progress notes, flow sheets, admission orders and interim care plans to determine if there were any residents on , that did not have orders to support the provision of care and services for the highest practicable wellbeing. Review confirmed that all

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Review of documentation from a long-term care hospital (LTCH), dated , indicated Resident #4 was hospitalized after a motor vehicle accident and apparent . The resident was intubated and suffered an Anoxic . Anoxic is "the lack of inadequate for several minutes or longer. cells begin to die after approximately four minutes without ." (Oxford dictionary). Resident #4 was also assessed to be in Acute (kidney) Failure, and in need of . Acute Failure means "the kidneys are unable to excrete the daily load of toxins in the ." (Oxford dictionary). is "a process of purifying the of a person whose kidneys are not working normally." (Wikipedia). The LTCH history and physical dated indicated the plan was to continue and incorporate the services of , the branch of medicine that deals with the kidneys (thefreedictionary.com/) and , the medical specialty that is concerned with the diagnosis and treatment of (thefreedictionary.com/), and monitor the resident for kidney function.

The most current documentation of the treatments was on the "Mobil Run Sheet", dated and . The run sheets indicated that Resident #4 required treatments up until the time she was admitted to the facility on , with the exception of a one time hold order on .

The LTCH's orders dated / through revealed Resident #4's laboratory work values (labs) were being

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residents on have orders to support the provision of care and services for the highest practicable wellbeing, consistent with the resident s assessment and plan of care.
On , 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new residents whether the resident would receive in-house or out-patient. This hold with remain in effect until the facility receives written clearance and confirmation of its substantial compliance.
The Medical Director was notified of citations on , 2016 and again on , 2017.
2. Identification of other residents having the potential to be affected:
The Director of Nursing (DON) or designee initiated re-education to all 26 licensed staff nurses and all scheduled contracted licensed nurses on 30, 2016, on the process of receipt and verification of order including hold orders as well as the completion and review of interim care plans within 24hrs of admission. The education also included the care of the resident on and the critical thinking skills need to address hold orders specific to including diagnostic tests and monitoring. All licensed facility staff nurses were re-educated as of 10, 2017 and all contracted nurses are re-educated prior to being placed on an assignment.
The Director of Nursing (DON) or designee continues to review orders for

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closely monitored to for kidney function to determine duration and frequency of the treatments. The physician's order, dated , indicated was needed 3 times a week on Monday, Wednesday, and Friday. The note, dated , the day before the resident was transferred to the facility, reflected that the resident's labs showed some signs of kidney recovery, but the resident was still dependent upon . The order, dated , indicated the resident required supplementation. The physician held that day and ordered labs for . A review of the lab results from the LTCH, dated at 1:55 AM, indicated the resident ' s labs were no longer in the normal range.

The LTCH's "Discharge Summary", dated , indicated Resident #4 had been closely monitored and would be discharged from the LTC hospital to a Skilled Nursing Facility (SNF). The summary reflected that a discussion was conducted with the family addressing diagnosis of in Chronic Kidney along with the need for and to be followed by the kidney doctors. The family voiced understanding and wished to get the resident to a SNF for further care, including .

Resident #4 was discharged from the LTCH and admitted to the SNF on , with diagnoses including in Chronic Kidney , Dependence on , Failure, Anoxic , a of the Sacral Region, and . The SNF included these diagnoses on their Admission Record.

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current residents on , 2017 and onward to determine if there were any residents without orders to support the provision of care and services for the highest practicable wellbeing. Review confirmed that all residents on have orders to support the provision of care and services for the highest practicable wellbeing, consistent with the resident s assessment and plan of care.
3. Actions taken/systems put into place to reduce the risk of future occurrence:
The Director of Nursing (DON) or designee initiated re-education on , 2017 to all licensed nurses on S483.24, S483.25 (k) (l). All nurses that have not received re-education on , 2017 will be re-educated before being placed on an assignment.
The Director of Nursing (DON) or designee will continue its current process through the post admission checks and the white board process (clinical review for new admissions chart, physicians orders, consults, acute change in condition, labs, and risk management) and review orders daily for all new admissions to ensure residents have orders to support the provision of care and services for the highest practicable wellbeing, consistent with the resident s assessment and plan of care.
4. How corrective action will be monitored:
The Director of Nursing (DON) or designee will audit the daily review of newly admitted residents orders at least three times weekly to ensure that newly admitted residents have orders to support

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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Review of the Admitting Minimum Data Set (MDS), dated , reflected the resident was assessed to have severely skills for daily decision making and rarely/never able to understand or be understood. Resident #4 was assessed to be bedridden and totally dependent on a staff of two for all activities of daily living. Resident #4 required an indwelling , and was of bowel. The MDS included the dependence on kidney in the diagnosis section of the assessment, but the assessment did not include the resident's treatments in the timeframe just prior to admission to the SNF.

Resident #4's admitting physician orders, dated , did not contain any documentation that the resident was to receive , and did not contain any orders for labs to monitor kidney function. The resident's admitting nurses' notes, dated , did not contain any documentation that the resident was to receive . The resident's admitting care plan, dated , did not contain documentation that the resident was to receive , and did not contain interventions to guide care and to monitor kidney function.

A physician's order given by Nurse Practitioner (NP) C on , was to begin in-house on Tuesday, Thursday and Saturday starting on / . The order was then discontinued before the resident received on / , and an order was written to hold for seven days, through / . There were no orders for any lab work to monitor kidney function.

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provision of care and services for the highest practicable wellbeing, consistent with the residents assessment and plan of care. Audit results will be reviewed monthly by the QAA/QAPI Committee. Any concerns or trends will be addressed with corrective actions as required.

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On at 12:15 PM, the director of nursing (DON) explained the process of the facility's "in-house" treatments. She said, " In order for a resident to receive in-house, the company has to review their records and accept the resident prior to admission. Our company had no record to begin for Resident #4." At 1:10 PM, the DON confirmed the resident was admitted to the facility from a LTCH on along with documentation the resident was receiving at the LTC hospital. The DON indicated the resident's last treatment for was on at the LTCH. She indicated that the discharge orders from the LTCH contained an order to "hold the on ," the day before Resident #4 was transferred to the facility from the LTCH. The DON indicated she spoke with the social worker at the LTCH and the nephrologist, and maintained the patient was removed from based on improved kidney lab values.

On at 2:57 PM, North Wing Unit Manager Licensed Practical Nurse (LPN) A, who had received the new physician orders regarding for Resident #4, indicated she had called the facility's physician on-call and had received the order to start and "hold" the from NP C. LPN A indicated she had called the facility's on-call physician on , and received the order to start because she did not see an order for it on the day the resident entered the facility on . She said the nurse took the order to hold the for 7 days from NP C on / . LPN A explained that she had called the company who would be

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performing the in-house treatments, and the company told her they had no record regarding treatment for Resident #4. LPN A said she informed NP C, and he gave her the order to hold for 7 days without any other orders or inquiry.

On at 9:32 AM via telephone, nephrologist E, who treated Resident #4 while at the LTCH, spoke about his order to "hold the on ." He indicated he had written the order on to hold based on Resident #4's laboratory value for , which was normal at that time. He said there was no conversation with the family regarding the discontinuation of because there would have needed to be more lab work obtained at a later date to make the decision if anymore was necessary. He also indicated he was not made aware of the Resident #4's discharge to the SNF, and would have continued close monitoring, additional lab work, and sessions.

On at 9:16 AM, the Admission's Coordinator (AC) confirmed she received the initial paperwork regarding Resident #4's referral to their facility via FAX from the LTCH on . She said the DON reviews the admission packets. The AC said when a resident comes to their facility, the resident gets a new nephrologist to follow kidney care. She said she did not know if the nephrologist was ever contacted regarding Resident #4.

A concurrent record review and interview was conducted on at 10:40 AM with NP C who gave the orders concerning for

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Resident #4. NP C indicated any resident on is closely monitored and if the levels were becoming stable, the resident would have repeat labs to monitor the kidney function. He confirmed that he did not order any labs to evaluate resident #4's kidney function while she was not receiving any . "The level shows how well your kidneys are working. A high level may mean your kidneys are not working as they should." (WebMD). NP C confirmed after reviewing records from the LTCH on that the nephrologist there had no intention of stopping Resident #4's . NP C said that he gave an order for on , and then to hold on for 7 days based on the information provided by the facility. NP C also indicated he could not find any evidence that would indicate the was to be stopped, and if he had known that the was only on hold on , he would have ordered a STAT (immediate) consult. "I can only base my decisions on the information provided by the facility. I did not see this resident till ."

Review of NP C's History and Physical, conducted on , indicated he reviewed the resident's medical record, including medications verified/reviewed, discussed with nurse, telephone orders reviewed, lab/ , hospital records reviewed. The visit note included AKI (acute kidney injury)/ (chronic kidney) history/of HD ( ). It did not include any assessment of kidney status or considering the need for . NP C did not write any orders to check the resident 's kidney function even after he documented he reviewed the LTCH records on .

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On at 11:26 AM via telephone, Physician F vaguely remembered the resident from the LTC hospital and could not remember if the NP C had spoken with him prior to writing the "hold" order. He said, "I would hope (NP C) would consult with me prior to providing care and treatment."

Resident #4, admitted to the facility with a , had been seen by the facility's care physician on and / . Review of the Care Evaluation, dated , indicated Resident #4 was assessed to have a non-specific and an unstageable (due to necrosis) sacrum measuring 8.7 centimeters (cm.) x 10.3 cm. The Care Evaluation, dated 11/ one week later, revealed resident #4 had developed nine additional wounds, "unstageable (due to necrosis) of the left ear, unstageable (due to necrosis) of the right ear, unstageable deep tissue injury (DTI) of the left lateral heel, unstageable DTI of the left lateral thigh, unstageable DTI of the left upper back, unstageable DTI of the left lateral neck, , of the right lateral neck, unstageable DTI of the right lateral calf and an unstageable DTI of the right lateral head."

Resident #4 was seen by the facility's care B weekly throughout her stay at the facility, through / . The Care Evaluation, dated , indicated Resident #4 was assessed to have a "non-specific " and an "unstageable (due to necrosis) sacrum measuring 8.7 cm. (centimeters) x 10.3 cm. A Surgical Debridement of Muscle procedure was performed

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to remove tissue and establish the margins of viable tissue. One week later, on /, the Care Evaluation indicated Resident #4 had developed nine additional wounds "unstageable of the left ear, unstageable of the right ear, unstageable deep tissue injury (DTI) of the left lateral heel, unstageable DTI of the left lateral thigh, unstageable DTI of the left upper back, unstageable DTI of the left lateral neck, , of the right lateral neck, unstageable DTI of the right lateral calf, and an unstageable DTI of the right lateral head."

On 3:30 PM, an interview was conducted with the facility's physician regarding resident #4's change in condition evidenced by the development of nine additional wounds in one week. She stated she saw the resident specifically for management. She described Resident #4 to be in a vegetative state and did not open her eyes. She confirmed the resident was seen by her twice while at the facility. Initially she saw her for one located on the sacral area, and then the following visit, one week later, the resident had developed nine additional wounds. At that point, the care physician said she called the family to discuss the process and proposed Resident #4 go to the emergency end of life care. The care physician stated she was not aware resident #4 had been on prior to coming to the facility. When the care physician reviewed the records from the LTCH and realized that this resident did not have any treatments for eleven (11) days since , she said not receiving may have contributed to the rapid decline in skin

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and could explain why Resident #4 had the nine new black wounds all over her body within a week. She said the wounds were Kennedy .. Kennedy (KTU) is the term used for "unavoidable or skin failure that occurs as part of the dying process (Schrank, 2009)." (virtualhospice...). The care physician gave the orders to send the resident to the emergency 3 PM /.

Resident #4's Physician Consultation, dated /, the day the resident was sent to the hospital from the SNF, reflected the resident had "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and Missing along with Hyperkalemia from Failure and Acidosis. The physician ordered Resident #4 to begin immediately with the prognosis of "POOR". Azotemia means "insufficient kidney filtering." (Azotemia.net). Uremia is a "serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them." (WebMD). Acidosis "is a condition in which there is too much in the body fluids." (Medlineplus.gov). The resident received hospice care within 5 days of transfer to the acute care hospital on /., and expired on .

The facility policy "Resident Rights" (no date) read, "The resident has the right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she prefers." The

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{F 309}	Continued From page 30 facility was unable to provide any policies regarding care and treatment. The facility failed to monitor Resident #4's kidney function and provide life sustaining The last time Resident #4 received was on . She did not receive any monitoring of kidney function after admission to the facility, and went eleven (11) days without The facility implemented sufficient measures to remove the immediacy and decrease the severity/scope as of , but the facility remains out of compliance with F309. The severity and scope of the deficiency was lowered to D-, no actual harm with potential for no more than minimal harm to residents. As of , the plan of correction was not submitted to include the facility's plans to fully implement, monitor performance, and evaluate the effectiveness of their action plans to ensure sustained compliance.	{F 309}		
{F 386} SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of and , which may	{F 386}		

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be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:

Based on interview, record review and policy review, the facility failed to ensure the physician took an active role in the care and treatment, including monitoring of kidney function and the review of the resident ' s condition to determine the need for , for 1 of 4 sampled residents (#4).

The resident's condition deteriorated to a level requiring hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired.

The facility's failure to monitor kidney status to identify the need for resulted in Immediate Jeopardy, staring on . This deficiency resulted in Substandard Quality of Care. Immediate Jeopardy was determined to be ongoing as of .

Findings:

Review of documentation from a long-term care hospital (LTCH), dated , indicated Resident #4 was hospitalized after a motor vehicle accident and apparent . The resident was intubated and suffered an Anoxic . Anoxic is "the lack of inadequate for several minutes or longer. cells begin to die after approximately four minutes without ." (Oxford dictionary). Resident #4 was also assessed to be in Acute (kidney) Failure, and in need of . Acute Failure

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F 386 Physician Visits- Review Care/Notes/Orders

1. Immediate actions taken:
Resident #4 had a closed chart and no longer resides in the facility.
During survey conducted , 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse, records reviewed included but was not limited to, records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, active drug lists, medication orders, treatment orders, Physician progress notes and admission orders to determine if there were any residents that did not have evidence of the active role of the physician in the care and treatment including monitoring of kidney function and the review of the resident s condition to determine the need for . Review confirmed that all residents on have evidence of the active role of the physician in the care and treatment including monitoring of kidney function and review of residents condition to determine the need for .
On , 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new residents whether the resident would receive in-house or out-patient. This hold with remain in effect

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means "the kidneys are unable to excrete the daily load of toxins in the ." (Oxford dictionary). is "a process of purifying the of a person whose kidneys are not working normally." (Wikipedia). The LTCH history and physical, dated , indicated the plan was to continue and incorporate the services of , the branch of medicine that deals with the kidneys (medical-dictionary.thefreedictionary.com/nephrology) and , the medical specialty that is concerned with the diagnosis and treatment of (medical-dictionary.thefreedictionary.com/nephrology), and monitor the resident for kidney function.

The LTCH follow-up plan was to continue and incorporate the services of and and monitor the resident for kidney function. The LTCH orders, dated / through revealed Resident #4's labs were being closely monitored to determine duration and frequency of the treatments. The LTCH Discharge Summary, dated , indicated Resident #4 had been closely monitored and would be discharged from the LTCH to a Skilled Nursing Facility (SNF). A discussion was conducted with the family addressing diagnosis of in Chronic Kidney along with the need for and to be followed by the kidney doctors. The family voiced understanding and wished to get the resident to a SNF for further care, including .

Resident #4 was discharged from the LTCH and admitted to the SNF on with diagnoses including in Chronic Kidney , Dependence on (kidney)

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until the facility receives written clearance and confirmation of its substantial compliance.
The Medical Director was notified of citations on , 2016 and again on , 2017.

2. Identification of other residents having the potential to be affected:
The Director of Nursing (DON) or designee continues to reviews orders for current residents from , 2017 and onward to determine if there are any residents that did not have evidence of the active role of the physician in the care and treatment for the resident. Review confirmed that all residents records have evidence of the active role of the physician in the care and treatment for the resident.
The Medical Director provided education to all four facility primary care physicians regarding the regulation specific to the physician s responsibility for the residents total plan of care, writing/signing/dating progress notes on each visit and signing and dating orders with special emphasis on required initial comprehensive visit and collaboration with on-call physicians, nurse practitioners, physicians with specialty practice such as a , nephrologist, urologist and the with documented proof as stated in S 483.30 (b) (1)-(3). This education was provided on , 2017.

3. Actions taken/systems put into place to reduce the risk of future occurrence:

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Failure, Anoxic , a of the Sacral Region, and

Review of the Admitting Minimum Data Set (MDS), dated , reflected the resident was assessed to have severely skills for daily decision making and rarely/never able to understand or be understood. Resident #4 was assessed to be bedridden and totally dependent on a staff of two for all activities of daily living. Resident #4 required an indwelling , and was of bowel. The MDS included the dependence on kidney in the diagnosis section of the assessment, but the assessment did not include the resident's treatments in the timeframe just prior to admission to the SNF.

Resident #4's admitting physician orders, dated , did not contain any documentation that the resident was to receive . The resident's admitting nurses' notes, dated , did not contain any documentation that the resident was to receive . The resident's admitting care plan, dated , did not contain documentation that the resident was to receive , and did not contain interventions to guide care, and to monitor kidney function.

On 1:10 PM, the Director of Nursing (DON) confirmed the resident was admitted to the facility from a LTCH on along with documentation the resident was getting at the LTCH. The DON indicated the resident's last treatment for was dated at the LTCH. She said the discharge orders from the LTCH contained an

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Medical Records conducts weekly physician visits review to ensure physician are in compliance with regulations and report to the Medical Director for follow up as needed.
Medical Director will continue to review the weekly audits of physicians visits to ensure compliance with S 483.30 (b) (1)-(3).

4. How corrective action will be monitored:
The Director of Nursing (DON) or designee conducts reviews of the results of weekly audits twice each month to ensure Physicians compliance with regulations and notifies the Medical Director accordingly.
The Director of Nursing (DON) or designee will review results of audits as part of the facility QAA/QAPI monthly for three months, quarterly for six months and randomly thereafter.

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order to "hold the on ".

On at 9:32 AM via telephone, nephrologist E who treated Resident #4 while at the LTCH, indicated he had written the order on to hold based on a laboratory value for which was normal at that time. He indicated conversation had not taken place with the family regarding the discontinuation of because there would have needed to be more labs at a later date to make the decision if anymore was necessary. Nephrologist E also indicated he was not made aware of the Resident #4's discharge from the LTCH and would have continued close monitoring and additional labs and sessions, at the facility.

Resident #4's physician's order was written by Nurse Practitioner (NP) C on , to begin in-house on Tuesday, Thursday and Saturday, starting on /. The order was later discontinued and a new order was written to hold for Resident #4 for seven (7) days, from / through . NP C gave an order to hold the for seven (7) days without a physician conducting an actual face to face examination and lab monitoring to determine appropriateness of care for Resident #4.

On at 10:40 AM, NP C, who had written the above orders concerning the plan of care for Resident #4, indicated any resident on is closely monitored and if their levels were becoming stable, the resident would have with repeat laboratory work (labs) obtained to monitor the resident's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 386}	Continued From page 35	{F 386}		

kidney function. He confirmed that no further labs were ordered by him to evaluate Resident #4's kidney function. NP C confirmed after reviewing records from the LTCH that the LTCH nephrologist had no intention of stopping Resident #4's . NP C said that he gave an order for on , and then to hold on /, based on the information provided by the facility. NP C also indicated he could not find any evidence that would indicate the was to be stopped, and if he had known the was only on "hold", he would have ordered a STAT (immediate) consult. He said, "I can only base my decisions on the information provided by the facility. I did not see this resident until ." NP C had not seen the resident or reviewed Resident #4's medical records prior to writing the order to "hold" for seven (7) days, from / through /. The resident's medical records provide invaluable information about the resident's prior and present medical condition. A review of the medical record is necessary in order to include an evaluation of the resident's condition and continued appropriateness of the current medical regime and plan of care. NP C did not order and monitoring of kidney function even though his visit notes and the history and physical, dated /, indicated he reviewed the LTCH record. NP C could not recall if he had consulted the primary care physician.

On at 11:26 AM, Resident #4's primary care physician F indicated he vaguely remembered the resident from the LTCH and could not remember if NP C had spoken with him prior to writing the "hold" order. He said, "I would hope (NP C) would consult with me

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	106027	A. BUILDING _____ B. WING _____	R-C 01/20/2017

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prior to providing care and treatment."

The facility was unable to provide documentation that the primary care physician had conducted the initial visit and reviewed Resident #4's labs to coordinate the plan of care and treatment for the resident.

The facility's care B weekly throughout her stay at the facility had seen Resident #4, from 11/ through 11/.

Review of the "Care Evaluation", dated , indicated Resident #4 was assessed to have a "non-specific ." and an "unstageable (due to necrosis) sacrum measuring 8.7 centimeters (cm.) x 10.3 cm." A Surgical Debridement of Muscle procedure was performed to remove tissue and establish the margins of viable tissue. The "Care Evaluation", dated / one week later, indicated Resident #4 had developed nine additional wounds "(unstageable (due to necrosis) of the left ear, unstageable (due to necrosis) of the right ear, unstageable deep tissue injury (DTI) of the left lateral heel, unstageable DTI of the left lateral thigh, unstageable DTI of the left upper back, unstageable DTI of the left lateral neck, of the right lateral neck, unstageable DTI of the right lateral calf and an unstageable DTI of the right lateral head."

On 3:30 PM, care B stated she did see Resident #4 for management and described the resident to be in a vegetative state and did not open her eyes. She confirmed the resident was seen by her twice while at the facility. Initially she saw her for one

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{F 386} Continued From page 37

located on the sacral area, and then the following visit one week later, the resident had developed nine additional wounds. At that point, care , B called the family to discuss the process and proposed Resident #4 be sent to the emergency end of life care. care B stated she had not been aware Resident #4 had been on prior to coming to the facility or that the had been on hold just prior to her admission. She indicated the discontinuation of Resident #4's may have contributed to the rapid decline in skin integrity and why Resident #4 had nine new black wounds all over her body within a week.

Review of the "Physician Consultation" dated / the day the resident was sent to the hospital from the SNF, indicated Resident #4 had "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and Missing along with Hyperkalemia from Failure and Acidosis. The physician placed an order for Resident #4 to begin STAT with the prognosis POOR. Resident #4 was placed on Hospice (/) and later expired ( ). Azotemia is "insufficient kidney filtering." (Azotemia.net). Uremia is a "serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them." (WebMD). Acidosis is "a condition in which there is too much in the body fluids." (medlineplus.gov).

On at 12:35 PM, the Administrator said, "We will take whoever (the physician or the NP) is

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{F 386}	Continued From page 38 available" to obtain orders for the residents. Review of the facility policy "Physician Visits and Physician Delegation", revised / , indicated the facility is to ensure the physician is taking an active role in supervising the care of residents and the review of the total program of care including medications and treatments in each visit. The facility failed to ensure a physician was taking an active role in supervising and monitoring the need for life sustaining treatments for Resident #4. The facility implemented sufficient measures to remove the immediacy and decrease the severity/scope as of / , but the facility remains out of compliance with F386. The severity and scope of the deficiency was lowered to D- , no actual harm with potential for no more than minimal harm to residents. As of , the plan of correction was not submitted to include the facility's plans to fully implement, monitor performance, and evaluate the effectiveness of their action plans to ensure sustained compliance.	{F 386}		
{F 388} SS=D	483.30(c)(3)(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP (c) Frequency of Physician Visits (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. (4) At the option of the physician, required visits in	{F 388}		

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SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse . in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review and policy review, the physician failed to provide an initial visit to assess and evaluate the monitoring of kidney function and the need for for 1 of 4 sampled residents reviewed for (#4).

The resident's condition deteriorated to a level requiring hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired.

The facility's failure to monitor kidney status to identify the need for resulted in Immediate Jeopardy, staring on . This deficiency resulted in Substandard Quality of Care. Immediate Jeopardy was determined to be ongoing as of .

Findings:

Review of documentation from a long-term care hospital (LTCH), dated , indicated Resident #4 presented after involvement in a motor vehicle accident and apparent . The resident was hospitalized, intubated, and suffered an Anoxic , "the lack of inadequate for several minutes or longer. cells begin to die after approximately four minutes without " (Oxford dictionary). Resident #4 was also assessed to be in Acute

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F 388 Provide Personal visits by Physician, Alternate PA/NP
1. Immediate actions taken:
Resident #4 had a closed chart and no longer resides in the facility.
During survey conducted 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse records reviewed included but was not limited to, records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, active drug lists, medication orders, treatment orders, Physician progress notes and admission orders to determine if there were any residents that did not have evidence of the physician providing initial visit to assess and evaluate the monitoring of kidney function and the need for .
Review confirmed that all residents on had evidence of the physician providing initial visit to assess and evaluate the monitoring of kidney function and the need for .
On , 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new residents whether the resident would receive in-house or

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{F 388}	Continued From page 40	{F 388}		

(kidney) Failure and in need of . Acute (kidney) Failure means "the kidneys are unable to excrete the daily load of toxins in the ." (Oxford dictionary). is "the clinical purification of to substitute for the absence of normal kidney function." (Oxford dictionary).

Resident #4's LTCH follow-up plan was to continue and incorporate the services of a nephrologist (kidney) and , and to monitor the resident's kidney function. The LTCH's orders, dated / through , revealed Resident #4's lab values were being closely monitored to determine duration and frequency of the treatments. The LTCH's Discharge Summary dated , indicated Resident #4 had been closely monitored and would be discharged from the LTC to a skilled nursing facility (SNF). According to the LTCH record, a discussion was conducted with the family addressing diagnosis of in Chronic Kidney along with the need for and to be followed by the kidney doctors. The LTCH record reflected the family voiced understanding and wished to get the resident to a SNF for further care.

Resident #4 was discharged from the LTCH and admitted to the SNF on with diagnoses including in Chronic Kidney , Dependence on , Failure, Anoxic , a of the Sacral Region, and .

Resident #4's admitting physician orders, dated , did not contain any documentation that the resident was to receive . The out-patient. This hold with remain in effect until the facility receives written clearance and confirmation of its substantial compliance.
The Medical Director was notified of citations on , 2016 and again on , 2017.

2. Identification of other residents having the potential to be affected:
The Medical Director provided education to all four facility primary care physicians and their nurse practitioners regarding their responsibility for the initial comprehensive visit being completed within 30 days of admission and only to be conducted by the primary care physician per regulation S483.30 C frequency of physician visits.
The Director of Nursing (DON) or designee continues to review current residents charts on , 2017 and onward to determine if there were any residents that did not have evidence of initial visit by the physician to assess and evaluate the monitoring of the residents plan of care. The review confirmed that all resident have evidence of initial visit by the physician to assess and evaluate the monitoring of the residents plan of care.

3. Actions taken/systems put into place to reduce the risk of future occurrence:
Medical Records conducts weekly physician visits review to ensure physician are in compliance with regulations.
Medical Director will continue to review the weekly audits of physicians visits to ensure compliance with S 483.30 C.

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resident's admitting nurses' notes, dated , did not contain any documentation that the resident was to receive . The resident's admitting care plan, dated , did not contain any documentation that the resident was to receive , and did not contain interventions to guide care.

On , Resident #4's physician's order, written by Nurse Practitioner (NP) C, reflected the resident was to begin in-house on Tuesday, Thursday and Saturday, starting on . This order was later discontinued, and NP C ordered to hold for Resident #4 for seven days, / through / .

On at 1:10 PM, the Director of Nursing (DON) confirmed the resident was admitted to the facility from a LTCH on along with documentation the resident was receiving at the LTCH prior to admission. The DON indicated the resident's last treatment for in the LTC hospital was on , and said the discharge orders from the LTCH read, "Hold the on ", the day before the resident was admitted to the facility. The DON was unable to explain why Resident #4 was not being monitored for kidney function to determine if additional was needed, and why the nephrologist was not contacted for clarification of the hold order.

On at 9:32 AM via telephone, nephrologist E who treated Resident #4 while at the LTCH indicated he had written the "hold" order on based on a laboratory value for , which was normal at that

4. How corrective action will be monitored:
The Director of Nursing (DON) or designee conducts reviews of the results of weekly audits twice each month to ensure Physicians compliance with regulations and notifies the Medical Director accordingly.
The Director of Nursing (DON) or designee will review results of audits as part of the facility QAA/QAPI monthly for three months then quarterly for six months and then randomly thereafter.

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{F 388}	Continued From page 42	{F 388}		

time. He said no conversation had taken place with the family regarding the discontinuation of as there would have needed to be more lab work at a later date to make the decision if anymore was necessary. Nephrologist E also indicated he was not made aware of the Resident #4's discharge from the LTCH, and would have continued close monitoring, additional lab work, and treatments in the facility.

On at 10:40 AM, NP C indicated any resident on is closely monitored, and if their levels were becoming stable, the resident would be given a trial of holding , and repeat lab work to monitor the resident's kidney function. He confirmed that he did not order any further labs to evaluate Resident #4's kidney function. NP C confirmed after reviewing Resident #4's records from the LTCH that the nephrologist at the LTCH had no intention of stopping the resident's . NP C said that he gave an order for on , and then to hold on , based on the information provided to him by the facility. NP C also indicated he could not find any evidence that would indicate the was to be stopped, and if he had known that the was only on hold, he would have ordered a STAT (immediate) consult. He said, "I can only base my decisions on the information provided by the facility. I did not see this resident until ." NP C had not seen the resident or reviewed Resident #4's medical records prior to writing the order to "hold" order for seven days, through . NP C could not recall if he had consulted the primary care physician.

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{F 388}	Continued From page 43	{F 388}		

On at 11:26 AM, Resident #4's primary care physician vaguely remembered the resident from the LTCH, and could not remember if NP C had spoken with him prior to writing the "hold" order. He said, "I would hope (NP C) would consult with me prior to providing care and treatment."

Resident #4's "Physician Consultation", dated /, the day the resident was sent to the hospital from the facility, assessed the resident with "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and missing along with Hyperkalemia from Failure and Acidosis. Azotemia is insufficient kidney filtering. (Azotemia.net). Uremia is a serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them. (WebMD). The physician ordered Resident #4 to begin immediately, and wrote the prognosis was "POOR". Resident #4 was placed on Hospice care on / and expired on .

On at 12:35 PM, the Administrator was asked about the physician conducting the initial visit to assess and write orders for Resident #4. He said, "We will take whoever (physician or NP) is available" to obtain orders for the resident.

The NP completed the initial comprehensive visit for Resident #4 seven (7) days after admission to the facility. NP C's documentation of the visit indicated it was conducted on / at 10:20 AM, and that the resident was a new admission.

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The history and physical contained the following areas reviewed and completed: history of present illness, , social history, family history, past history, 14-point review of systems examination, including general, , head, ear, nose, throat, neck, lungs, , abdomen, extremities, , , dermatological, and Assessment and Plan. The following areas were checked: admit to facility, Rehab therapies ordered, medications verified/reviewed, discussed with nurse, telephone orders reviewed, lab/ , hospital records reviewed. The visit note also included AKI (acute kidney injury)/ (chronic kidney) history/of HD (,). It did not include any assessment of kidney status or . A comprehensive type of examination includes at least nine organ systems or body areas. (CMS.gov). Although this information was documented as completed by NP C, on , at 10:40 AM, he said, if he had known that the was only on hold, he would have ordered a STAT (immediate) consult.

The facility policy "Physician Visits and Physician Delegation", revised / , contained a chart documenting the following information: "In a Skilled Nursing Facility, Initial Comprehensive Visits/Orders MAY NOT be Performed or Signed by a Physician Assistant, Nurse Practitioner or Clinical Nurse , employed or not employed by the facility."

The facility failed to ensure a physician conducted the first initial visit, and monitor the life sustaining treatment for Resident #4.

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The facility implemented sufficient measures to remove the immediacy and decrease the severity/scope as of , but the facility remains out of compliance with F388. The severity and scope of the deficiency was lowered to D- , no actual harm with potential for no more than minimal harm to residents. As of , the plan of correction was not submitted to include the facility's plans to fully implement, monitor performance, and evaluate the effectiveness of their action plans to ensure sustained compliance.

Agency for Health Care Administration

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{N 000}	INITIAL COMMENTS Compliant Investigations#2016012160 #2016013398 were conducted from to . Avante at Orlando had a deficieincy at the time of the visit.	{N 000}		
{N 201} SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interview, record review and policy review, the facility failed to provide adequate and appropriate care and services for 1 of 4 sampled residents reviewed for , services, and failed to monitor kidney function (#4). , a life sustaining treatment, was not given, and kidney function status was not obtained. The resident's condition deteriorated to a level requiring hospitalization within 8 days of admission to the facility. The resident received hospice care within 5 days of transfer to the acute care hospital and expired. The facility's failure to monitor kidney status to identify the need for resulted in a Class I deficiency, starting on . Findings: Review of documentation from a long-term care hospital (LTCH), dated , indicated	{N 201}	N 201 400.022(1)(l), FS Right to Adequate and Appropriate Health Care. 1. Immediate actions taken: Resident #4 had a closed chart and no longer resides at this facility. During survey conducted , 2016 through , 2016 and on , 2017, the medical records of all residents on were reviewed by the DON and RN corporate nurse, records reviewed included but was not limited to, records received from discharging facility (hospital or LTACH), and those generated at Avante at Orlando including history and physical, consultation notes, /OT/ST evaluations/progress notes, active drug lists, medication orders, treatment orders, Physician progress notes, flow sheets, admission orders and interim care	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Approved by MCA 2/7/17

Agency for Health Care Administration

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{N 201}	Continued From page 1	{N 201}		

Resident #4 was hospitalized after a motor vehicle accident and apparent [illegible]. The resident was intubated and suffered an Anoxic [illegible]. Anoxic [illegible] is "the lack of inadequate [illegible] for several minutes or longer. [illegible] cells begin to die after approximately four minutes without [illegible]." (Oxford dictionary). Resident #4 was also assessed to be in Acute [illegible] (kidney) Failure, and in need of [illegible]. Acute [illegible] Failure means "the kidneys are unable to excrete the daily load of toxins in the [illegible]." (Oxford dictionary). [illegible] is "a process of purifying the [illegible] of a person whose kidneys are not working normally." (Wikipedia). The LTCH history and physical dated [illegible] indicated the plan was to continue [illegible] and incorporate the services of [illegible], the branch of medicine that deals with the kidneys (thefreedictionary.com/ [illegible]) and [illegible], the medical specialty that is concerned with the diagnosis and treatment of [illegible] (thefreedictionary.com/ [illegible]), and monitor the resident for kidney function.

The most current documentation of the [illegible] treatments was on the "Mobil [illegible] Run Sheet", dated [illegible], [illegible] and [illegible]. The run sheets indicated that Resident #4 required [illegible] treatments up until the time she was admitted to the facility on [illegible], with the exception of a one time hold order on [illegible]. The LTCH's [illegible] orders dated [illegible] through [illegible] revealed Resident #4's laboratory [illegible] work values (labs) were being closely monitored to for kidney function to determine duration and frequency of the [illegible] treatments. The physician's order, [illegible] plans to ensure that immediate care needs were met and that facility monitored kidney status to identify the need for [illegible]. All records reviewed confirmed there was evidence of appropriate monitoring of kidney status and all care needs were met.
On [illegible], 2016 the Administrator directed the Admissions Coordinator and External Marketer to cease admission of new [illegible] residents whether the resident would receive [illegible] in-house or out-patient. This hold with remain in effect until the facility receives written clearance and confirmation of its substantial compliance.
The Medical Director was notified of citations on [illegible], 2016 and again on [illegible], 2017.

2. Identification of other residents having the potential to be affected:
On [illegible], 2016 the Director of Nursing (DON) or designee initiated re-education to all 26 licensed staff nurses and all scheduled contracted licensed nurses on the process of receipt and verification of orders including hold orders as well as the completion and review of interim care plans within 24hrs of admission. The education also included the care of the resident on [illegible] and the critical thinking skills need to address hold orders specific to [illegible] including diagnostic tests and monitoring. All licensed facility staff nurses were re-educated as of [illegible], 2017 and all contracted nurses are re-educated prior to being placed on an assignment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT ORLANDO INC	2000 NORTH SEMORAN BOULEVARD ORLANDO, FL 32807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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dated , indicated was needed 3 times a week on Monday, Wednesday, and Friday. The note, dated , the day before the resident was transferred to the facility, reflected that the resident's labs showed some signs of kidney recovery, but the resident was still dependent upon . The order, dated , indicated the resident required supplementation. The physician held that day and ordered labs for . A review of the lab results from the LTCH, dated at 1:55 AM, indicated the resident's labs were no longer in the normal range.
The LTCH's "Discharge Summary", dated , indicated Resident #4 had been closely monitored and would be discharged from the LTC hospital to a Skilled Nursing Facility (SNF). The summary reflected that a discussion was conducted with the family addressing diagnosis of in Chronic Kidney along with the need for and to be followed by the kidney doctors. The family voiced understanding and wished to get the resident to a SNF for further care, including .
Resident #4 was discharged from the LTCH and admitted to the SNF on , with diagnoses including in Chronic Kidney , Dependence on , Failure, Anoxic , a of the Sacral Region, and . The SNF included these diagnoses on their Admission Record.

Review of the Admitting Minimum Data Set (MDS), dated / /, reflected the resident was assessed to have severely skills for daily decision making and rarely/never able to understand or be understood. Resident #4 was assessed to be bedridden and totally

The Director of Nursing (DON) or designee continues to review orders for current residents on , 2017 and onward to ensure that the facility is monitoring residents process with standards that meet professional standards as stated in the Nurse Practice Act S464.003 (3) (a) (1) (2). All records reviewed confirmed there was evidence of the appropriate monitoring and management of residents processes.

3. Actions taken/systems put into place to reduce the risk of future occurrence:
The Director of Nursing (DON) or designee initiated re-education on , 2017 to all licensed nurses on standards that meet professional standards as reflected in the Nurse Practice Act S464.003 (3) (a) (1) (2). All nurses that have not received re-education on , 2017 will be re-educated prior to being placed on an assignment. The Director of Nursing (DON) or designee will continue, through the white board process (clinical review for new admissions chart, physicians orders, consults, acute change in condition, labs, and risk management) and review orders, interim care plans for all new admissions daily to ensure orders and interventions are present that reflect the management and monitoring of residents processes.
4. How corrective action will be monitored:
The Director of Nursing (DON) or designee will audit the daily review of newly admitted residents orders at least

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dependent on a staff of two for all activities of daily living. Resident #4 required an indwelling , and was of bowel. The MDS included the dependence on kidney in the diagnosis section of the assessment, but the assessment did not include the resident ' s treatments in the timeframe just prior to admission to the SNF.

Resident #4's admitting physician orders, dated , did not contain any documentation that the resident was to receive , and did not contain any orders for labs to monitor kidney function. The resident's admitting nurses' notes, dated , did not contain any documentation that the resident was to receive . The resident's admitting care plan, dated , did not contain documentation that the resident was to receive , and did not contain interventions to guide care and to monitor kidney function.

A physician's order given by Nurse Practitioner (NP) C on , was to begin in-house on Tuesday, Thursday and Saturday starting on 1/ . The order was then discontinued before the resident received on , and an order was written to hold for seven days, 1/ through 11/ . There were no orders for any lab work to monitor kidney function.

On at 12:15 PM, the director of nursing (DON) explained the process of the facility's "in-house" treatments. She said, "In order for a resident to receive in-house, the company has to review their records and accept the resident prior to admission. Our company had no

three times weekly to ensure that newly admitted residents have orders to support provision of care and services for the highest practicable wellbeing, consistent with the residents assessment and plan of care. Audit results will be reviewed monthly by the QAA/QAPI Committee. Any concerns or trends will be addressed with corrective actions as required.

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record to begin for Resident #4." At 1:10 PM, the DON confirmed the resident was admitted to the facility from a LTCH on along with documentation the resident was receiving at the LTC hospital. The DON indicated the resident's last treatment for was on at the LTCH. She indicated that the discharge orders from the LTCH contained an order to "hold the on ," the day before Resident #4 was transferred to the facility from the LTCH. The DON indicated she spoke with the social worker at the LTCH and the nephrologist, and maintained the patient was removed from based on improved kidney lab values.

On at 2:57 PM, North Wing Unit Manager Licensed Practical Nurse (LPN) A, who had received the new physician orders regarding for Resident #4, indicated she had called the facility's physician on-call and had received the order to start and "hold" the from NP C. LPN A indicated she had called the facility's on-call physician on , and received the order to start because she did not see an order for it on the day the resident entered the facility on . She said the nurse took the order to hold the for 7 days from NP C on / . LPN A explained that she had called the company who would be performing the in-house treatments, and the company told her they had no record regarding treatment for Resident #4. LPN A said she informed NP C, and he gave her the order to hold for 7 days without any other orders or inquiry.

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On at 9:32 AM via telephone, nephrologist E, who treated Resident #4 while at the LTCH, spoke about his order to "hold the on ." He indicated he had written the order on to hold based on Resident #4's laboratory value for , which was normal at that time. He said there was no conversation with the family regarding the discontinuation of because there would have needed to be more lab work obtained at a later date to make the decision if anymore was necessary. He also indicated he was not made aware of the Resident #4's discharge to the SNF, and would have continued close monitoring, additional lab work, and sessions.

On at 9:16 AM, the Admission's Coordinator (AC) confirmed she received the initial paperwork regarding Resident #4's referral to their facility via FAX from the LTCH on . She said the DON reviews the admission packets. The AC said when a resident comes to their facility, the resident gets a new nephrologist to follow kidney care. She said she did not know if the nephrologist was ever contacted regarding Resident #4.

A concurrent record review and interview was conducted on at 10:40 AM with NP C who gave the orders concerning for Resident #4. NP C indicated any resident on is closely monitored and if the levels were becoming stable, the resident would have repeat labs to monitor the kidney function. He confirmed that he did not order any labs to evaluate resident #4's kidney function while she was not receiving any "The level shows how well your kidneys are working. A high level may mean your

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kidneys are not working as they should." (WebMD). NP C confirmed after reviewing records from the LTCH on that the nephrologist there had no intention of stopping Resident #4's . NP C said that he gave an order for on , and then to hold on for 7 days based on the information provided by the facility. NP C also indicated he could not find any evidence that would indicate the was to be stopped, and if he had known that the was only on hold on , he would have ordered a STAT (immediate) consult. "I can only base my decisions on the information provided by the facility. I did not see this resident till ."

Review of NP C's History and Physical, conducted on , indicated he reviewed the resident's medical record, including medications verified/reviewed, discussed with nurse, telephone orders reviewed, lab/ , hospital records reviewed. The visit note included AKI (acute kidney injury)/ (chronic kidney) history/of HD ( ). It did not include any assessment of kidney status or considering the need for . NP C did not write any orders to check the resident's kidney function even after he documented he reviewed the LTCH records on .

On at 11:26 AM via telephone, Physician F vaguely remembered the resident from the LTC hospital and could not remember if the NP C had spoken with him prior to writing the "hold" order. He said, "I would hope (NP C) would consult with me prior to providing care and treatment."

Resident #4, admitted to the facility with a

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, had been seen by the facility's care physician on and / . Review of the Care , Evaluation, dated , indicated Resident #4 was assessed to have a non-specific and an unstageable (due to necrosis) sacrum measuring 8.7 centimeters (cm.) x 10.3 cm. The Care , Evaluation, dated / , one week later, revealed resident #4 had developed nine additional wounds, "unstageable (due to necrosis) of the left ear, unstageable (due to necrosis) of the right ear, unstageable deep tissue injury (DTI) of the left lateral heel, unstageable DTI of the left lateral thigh, unstageable DTI of the left upper back, unstageable DTI of the left lateral neck, , of the right lateral neck, unstageable DTI of the right lateral calf and an unstageable DTI of the right lateral head."

Resident #4 was seen by the facility's care B weekly throughout her stay at the facility, through / . The Care , Evaluation, dated , indicated Resident #4 was assessed to have a "non-specific ." and an "unstageable (due to necrosis) sacrum measuring 8.7 cm. (centimeters) x 10.3 cm. A Surgical Debridement of Muscle procedure was performed to remove tissue and establish the margins of viable tissue. One week later, on , the Care , Evaluation indicated Resident #4 had developed nine additional wounds "unstageable of the left ear, unstageable of the right ear, unstageable deep tissue injury (DTI) of the left lateral heel, unstageable DTI of the left lateral thigh, unstageable DTI of the left upper back, unstageable DTI of the left lateral neck, , of the right lateral neck,

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unstageable DTI of the right lateral calf, and an unstageable DTI of the right lateral head."

On 3:30 PM, an interview was conducted with the facility's physician regarding resident #4's change in condition evidenced by the development of nine additional wounds in one week. She stated she saw the resident specifically for management. She described Resident #4 to be in a vegetative state and did not open her eyes. She confirmed the resident was seen by her twice while at the facility. Initially she saw her for one located on the sacral area, and then the following visit, one week later, the resident had developed nine additional wounds. At that point, the care physician said she called the family to discuss the process and proposed Resident #4 go to the emergency end of life care. The care physician stated she was not aware resident #4 had been on prior to coming to the facility. When the care physician reviewed the records from the LTCH and realized that this resident did not have any treatments for eleven (11) days since , she said not receiving may have contributed to the rapid decline in skin and could explain why Resident #4 had the nine new black wounds all over her body within a week. She said the wounds were Kennedy . Kennedy (KTU) is the term used for "unavoidable or skin failure that occurs as part of the dying process (Schrank, 2009)." (virtualhospice.). The care physician gave the orders to send the resident to the emergency 3 PM / .

Resident #4's Physician Consultation, dated

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11/ , the day the resident was sent to the hospital from the SNF, reflected the resident had "Severe Azotemia and Uremia causing resident to have a change in mental status, Acidosis from possibly and Missing along with Hyperkalemia from Failure and Acidosis. The physician ordered Resident #4 to begin immediately with the prognosis of "POOR". Azotemia means "insufficient kidney filtering." (Azotemia.net). Uremia is a "serious complication of chronic kidney when urea and other waste products build up in the body because the kidneys are unable to eliminate them." (WebMD). Acidosis "is a condition in which there is too much in the body fluids." (Medlineplus.gov). The resident received hospice care within 5 days of transfer to the acute care hospital on / , and expired on .

The facility policy "Resident Rights" (no date) read, "The resident has the right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she prefers." The facility was unable to provide any policies regarding care and treatment.
The facility failed to monitor Resident #4's kidney function and provide life sustaining .
The last time Resident #4 received was on . She did not receive any monitoring of kidney function after admission to the facility, and went eleven (11) days without .

Class I

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Avante At Orlando Inc
2000 North Semoran Boulevard
Orlando, FL 32807

RE: CCR #2016012160 and 2016013398

Dear Administrator:

On 27 to , 2016, a survey was conducted in your facility by representative(s) of this office. Your facility was found not in substantial compliance with the participation requirements. A partial extended survey was conducted on , 2017.

The findings of the survey revealed Immediate Jeopardy at
F0271 -- S/S: J -- 483.20(a) -- Admission Physician Orders for Immediate Care
F0281 -- S/S: J -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards
F0309 -- S/S: J -- 483.24, 483.25(k)(l) -- Provide Care/Services For Highest Well Being
F0386 -- S/S: J -- 483.30(b)(1)-(3) -- Physician Visits-Review care/notes/orders
F0388 -- S/S: J -- 483.30(c)(3)(4) -- Personal Visits By Physician
identified on , 2016, which was removed on , 2017.

Your facility's noncompliance with F0309 -- S/S: J -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being has been determined to constitute substandard quality of care as defined at §488.301. **Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(b) require that the attending physician of the affected resident, who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide this office with the name and address of the attending physician of the affected residents in your facility within 10 working days of your receipt of this letter. Please note that, in accordance with §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.**

List of affected resident(s): #4

As a result of the survey, this Agency is forwarding a copy of the CMS-2567 to the Centers for Medicare and Medicaid Services (CMS) and a copy of these results to you.

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

You will not receive a copy of this letter and attachments in the mail; you will only receive this electronic report.

CMS will communicate with you after they have received this documentation.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Our findings reflect that your facility continues not to be in substantial compliance since the survey of , 2017.

The change in the seriousness of the noncompliance from the visit on , 2017 has resulted in a change in the remedy/ies.

Recommended Remedies:

Remedies will be recommended for imposition by CMS or the State Medicaid Agency.

- **Civil Money Penalty, in an amount and duration to be determined by CMS.**
- **Discretionary denial of payment for new admissions Medicare/Medicaid as soon as notice requirements are met.**
- **Termination of the Medicare Agreement effective , 2017.**

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or

Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

If you have questions, please contact Theresa DeCanio, RN at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

tdc/mad
Enclosure

TCTN